STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155329	A. BUILDING 01 B. WING	04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSEWALK VILLAGE AT INDIANAPOLIS	1302 N LESLEY AVE INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 04/16/11 Facility Number: 000222 Provider Number: 155329 AIM Number: 100274950 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Rosewalk Village at Indianapolis was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all areas open to the corridor. Battery operated smoke	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests desk review (paper compliance) on or after 5/4/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	detection is provided in all resident sleeping rooms. The facility has a capacity of 182 and had a census of 151 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 04/19/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure the means of egress through 1 of 1 delayed egress locks in the Therapy Room was readily accessible for residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks, says approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that: (d) On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS This deficient practice could affect any resident, staff or visitor wanting to exit the facility by using the Therapy Room exit.	K0038	K038 1. No residents were found to have been affected by this alleged deficient practice. 2. Any other resident wanting to exit the facility by using the therapy room exit could have been affected by this alleged deficient practice. Egress sensitivity setting was adjusted and door is functioning per code as of 4/17/2012. Codes to the eleven doors were posted as of 4/17/2012 3. All delayed egress doors in the facility have been inspected and are functioning properly. Any new doors installed with delayed egress hardware will be tested to ensure proper function. 4. Maintenance supervisor will audit facility delayed egress doors monthly for 3 months to ensure appropriate signage is affixed. Maintenance will audit 11 doors monthly to ensure codes are posted. Results will be take to CQI committee for recommendations. 5. Systemic changes will be in place by 5/8/12	05/08/2012

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	Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:10 a.m. to 1:35 p.m. on 04/16/12, the Therapy Room exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force two separate times. The Therapy Room exit door delayed egress lock released when the fire alarm was activated at 1:13 p.m. on 04/16/12. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the Therapy Room exit door is equipped with a delayed egress lock which was provided with signage stating the door could be opened in 15 seconds by pushing on the door with the application of force to the release device within 15 seconds but the exit door did not release within 15 seconds when the door was pushed with the application of force two separate times. 3.1-19(b) 2. Based on observation and interview,			

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	the facility failed to ensure the means of egress through 1 of 11 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. This deficient practice affects any resident, staff or visitor needing to exit the facility by Room 123. Findings include: Based on observation with the Maintenance Supervisor and the Executive Director during a tour of the facility from 11:10 a.m. to 1:35 p.m. on 04/16/12, eleven exit doors were magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit door by Room 123. The exit access by Room 123 has two exit doors in series in the path of egress which each could be opened by			

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	entering a four digit code but the code was not posted at the second exit door which discharged directly to the exterior of the building. Based on interview with the Executive Director at the time of observation, approximately 50 % of the residents do not have a clinical diagnosis to be in a secure building. A resident without the clinical diagnosis requiring specialized security measures would have to ask a staff member to let them out if they did not know the exit access code. The delayed egress lock on the exit door by Room 123 which discharges directly to the exterior of the building released when the fire alarm was activated at 1:13 p.m. Based on interview at the time of observation, the Maintenance Supervisor stated the four digit exit code was not the same code for each exit door and acknowledged the four digit exit code was not posted at the second exit door which discharged directly to the exterior of the building. 3.1-19(b)			

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on record review, observation and interview; the facility failed to ensure emergency power would be transferred to the emergency generator within 10 seconds of building power loss for 10 of 12 months. NFPA 99, 3-4.1.1.8 states generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. NFPA 99, 3-5.4.2 requires a written record of inspection, performance, exercising period and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect all residents, staff and visitors. Findings include: a. Based on review of "Emergency Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:10 a.m. on 04/16/11, monthly load test documentation for 09/29/11, 12/31/11, 01/30/12, 02/29/11 and 03/29/11 lists the	K0144	K144 1. No residents were found to have been affected by this alleged deficient practice. 2. All residents in the facility had the potential to be affected by the alleged deficient practice. Emergency generator was repaired on 4/18/2012 so that transfer of power takes place in less than 10 seconds. 3. Emergency generator will be tested on a monthly basis to ensure power transfers within 10 seconds. If transfer takes longer than 10 seconds, appropriate repairs will be ordered immediately. 4. Maintenance supervisor will audit monthly on going the power transfer to ensure transfer within 10 seconds. Results will be taken to CQI committee for recommendations. 5. Systemic changes will be in place by 5/8/12	05/08/2012

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	transfer time as 12 seconds, monthly load test documentation for 06/27/11 and 07/28/11 lists the transfer time as 13 seconds, monthly load test documentation for 10/31/11 lists the transfer time as 15 seconds and monthly load test documentation for 04/29/11 lists the transfer time as 11 seconds. b. Based on observation with the Maintenance Supervisor during a tour of the facility from 11:10 a.m. to 1:35 p.m. on 04/16/12, when the emergency generator was manually started the transfer time was 11.5 seconds. The transfer time was recorded with a timer on the Maintenance Supervisor's cellular phone. Based on interview at the time of record review and observation, the Maintenance Supervisor acknowledged it took more than 10 seconds to transfer building power to the emergency generator for 10 of 12 months. 3.1-19(b)			

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K0154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 Based on record review and staff interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.7.6.1 in order to protect 151 of 151 residents. LSC 9.7.6.2 requires sprinkler impairment procedures comply with NFPA 25, 1998 Edition, the Standard for Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 11-5(d) requires the local fire department be notified of sprinkler impairment and 11-5(e) requires the insurance carrier, alarm company, building owner/manager and other authorities having jurisdiction also be notified. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Plan: Fire	K0154	K154 1. No residents were found to have been affected by this alleged deficient practice. 2. All residents in the facility had the potential to be affected by the alleged deficient practice. The Disaster Plan: fire watch policy has been amended to specify that fire watch will be intiated in the event that the automatic sprinkler system has to be placed out of service for 4 or more hours in a 24 hr period. 3. When the automatic sprinkler system has to be placed out of service for 4 or more hours in a 24 hr period, the maintenance supervisor will notify the Executive Director and will confirm that fire watch has been initiated. Executive Director or designee will inform all necessary entities if the facility is on fire watch. 4. Maintenance supervisor will audit for 3 months each time the automatic sprinkler system has to be placed out of service for 4 or more hours in a 24 hr period that fire watch was appropriately initiated and that all necessary entities were	05/08/2012

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	Watch Policy and Procedure" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:10 a.m. on 04/16/12, the following was noted: a. the fire watch policy did not include a statement of the fire watch being initiated in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. b. the fire watch "Procedure" section states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility's written fire watch policy did not include initiation of the fire watch and notification to all necessary entities in the event the automatic sprinkler system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b)		notified. Results will be taken to the CQI committee for recommendations. 5. Systemic changes will be in place by 5/8/12	

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K0155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 Based on record review and staff interview, the facility failed to provide a complete written policy containing procedures to be followed in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period in accordance with LSC, Section 9.6.1.8 in order to protect 151 of 151 residents. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of "Disaster Plan: Fire Watch Policy and Procedure" documentation with the Maintenance Supervisor during record review from 9:25 a.m. to 11:10 a.m. on 04/16/12, the following was noted: a. the fire watch policy did not include a statement of the fire watch being initiated in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. b. the fire watch "Procedure" section states "Call 911 to report the fire. The	K0155	K155 1. No residents were found to have been affected by this alleged deficient practice. 2. All residents in the facility had the potential to be affected by the alleged deficient practice. The Disaster Plan: fire watch policy and procedure has been amended to specify that fire watch will be intiated in the event that the fire alarm system has to be placed out of service for 4 or more hours in a 24 hr period. 3. When the fire alarm system has to be placed out of service for 4 or more hours in a 24 hr period, the maintenance supervisor will notify the Executive Director and will confirm that fire watch has been initiated. Executive Director or designee will inform all necessary entities if the facility is on fire watch. 4. Maintenance supervisor will audit for 3 months each time the fire alarm system has to be placed out of service for 4 or more hours in a 24 hr period that fire watch was appropriately initiated and that all necessary entities were notified.	05/08/2012

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	facility's ED or designee will notify all necessary entities." The facility's written fire watch policy stated the authority having jurisdiction, the Indiana State Department of Health, would only be notified in the event of a fire. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility's written fire watch policy did not include initiation of the fire watch and notification to all necessary entities in the event the fire alarm system has to be placed out of service for 4 hours or more in a 24 hour period. 3.1-19(b))		Results will be taken to the CQI committee for recommendations. Systemic changes will be in place by 5/8/12	